Father Hudsons Society

St Joseph's

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 04 February 2016 and was unannounced.

St Joseph's is registered to provide care and accommodation for up to 60 older people. The service is provided across four 'wings' over two floors. At the time of our inspection visit there were 59 people living there.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were comfortable with the staff who supported them and relatives were confident people were safe living in the home. Staff received training in how to safeguard people from abuse and understood what action they should take in order to protect people from harm. However, recordings they were expected to make when raising safeguarding concerns had not always been completed. Risks to people's safety were identified, minimised and flexed towards individual needs so people could be supported in the least restrictive way possible and build their independence. However, risk assessments were not always up to date and checks had not identified this.

People were supported with their medicines by staff who were trained and assessed as competent to give medicines safely. Medicines were given in a timely way and as prescribed. Regular checks designed to ensure medicines were administered safely had not always identified gaps in people's medication records.

There were enough staff to meet people's needs effectively. The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people who lived in the home. Staff told us they were not able to work until these checks had been completed.

The provider ensured staff had information on the level of support people needed with decision-making so people were protected. Staff and the registered manager had a good understanding of the Mental Capacity Act, and the need to seek informed consent from people before delivering care and support. Where restrictions were in place, legal processes had been followed to ensure they were in people's 'best interests', and applications for legal authorisation had been sent to the relevant authorities.

Staff were respectful and treated people with dignity and respect. We observed this in interactions between people, and records confirmed how people's privacy and dignity was maintained. People were supported to make choices about their day to day lives and to maintain any activities, interests and relationships that were important to them.

People had access to health professionals when needed and we saw the care and support provided in the

home was in line with what had been recommended. Health professionals told us they were confident the provider managed people's health effectively. People's care records were written in a way which helped staff to deliver personalised care and gave staff information about people's communication, their likes, dislikes and preferences. People were involved in how their care and support was delivered as much as possible. Where people were unable to communicate their views, staff talked to people's families or their representatives to ensure people's care was appropriate to their needs.

Relatives told us they felt able to raise any concerns with the registered manager. They felt these would be listened to and responded to effectively and in a timely way. Staff told us the management team were approachable and responsive to their ideas and suggestions. There were systems in place to monitor the quality of the support provided in the home. However, these systems had not always worked as intended. Gaps and inconsistencies in record keeping had not been identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's needs had been assessed and risks to their safety were identified. However, risk assessments were not always up to date and we could not be sure people were always supported safely as a result. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse. However, these procedures had not always been followed. People received their medicines from trained and competent staff. However, medicine administration records had not always been completed as they should have been. There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People's rights were protected. Where people lacked the capacity to make all of their own decisions, the provider protected people's rights under the Mental Capacity Act (MCA) by assessing people's capacity and the support people needed with decision-making. Staff sought consent from people about how their needs should be met. People were supported by staff that were competent and trained to meet their needs effectively. People were offered a choice of meals and drinks that met their dietary needs. People received timely support from health care professionals when needed to assist them in maintaining their health.

Is the service caring?

Good

The service was caring.

People were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs and staff had a good knowledge and understanding of people's likes, dislikes and preferences. Staff showed respect for people's privacy and talked with them in ways they could understand.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which had been planned with their involvement, or the involvement of people who were important to them. People's care and support plans were regularly reviewed to ensure they were meeting people's needs. People were helped to maintain activities and interests outside the home environment. People knew how to raise complaints and were supported to do so.

Is the service well-led?

Good

The service was well led.

People felt able to approach the management team and were listened to when they did. Staff felt supported in their roles which meant there was a culture of free and open communication between staff and the registered manager. Records were not always completed when they should have been, and this had not been identified in audits undertaken.

St Joseph's

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 04 February 2016 and was unannounced. The inspection was conducted by two inspectors.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

We reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information as part of our evidence when conducting our inspection, and found it reflected what we saw during our inspection visit.

During our inspection visit, we spoke with 12 people who lived in the home. We also spent time observing interactions between people and staff. We spoke with five relatives, and two health professionals. We also spoke to the registered manager, two assistant managers and six care staff.

We reviewed eight people's care plans, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. One person told us, "Yes, this place is safe. I feel safe." Another person said, "Yes (they felt safe), I have a key for my room but I never lock it." We spent time observing the interactions between the people living in the home and the staff supporting them. We saw people were relaxed and comfortable around staff and responded positively when staff approached them. Relatives told us they thought people were safe and well cared for. One relative told us, "[Person] is safe, clean and comfortable."

The provider protected people from the risk of harm and abuse. Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. They also understood how to look for signs that might be cause for concern. One staff member told us, "I would go straight to the manager if I had any concerns, and they would be there straight away." Staff told us they had access to a phone number to report any incidents if they did not want to report 'in house'.

There were policies and procedures for staff to follow should they be concerned that abuse had happened, but these had not always been followed. For example, some records indicated one person had sustained some bruising on two separate occasions and that some of the bruising was unexplained. We discussed this with the registered manager who was not aware of the incident. We were told by the registered manager that any incident of bruising should be entered on a body map (a body map is a picture of the human body on which staff can indicate an injury, bruise or mark), details of the bruising entered on the person's records and an incident form completed which was passed to the registered manager. This procedure had not been followed. There was a body map for the bruising however this was not fully detailed, no entries could be found on the person's records and no incident record had been completed. What was thought to be the cause of some of the bruising was recorded and action had been taken to ensure this could not happen again.

The provider's recruitment process ensured risks to people's safety were minimised, and that staff with the right skills, knowledge and values were brought in to work at the home. One person told us, "I had a business and I did what they do. They pick the right people." Staff told us they had to wait for checks and references to come through before they started working in the home. Records showed the registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about potential new staff. The DBS is a national agency that keeps records of criminal convictions.

Risks relating to people's care needs had been identified and assessed according to their individual needs and abilities. Action plans were written with guidance for staff on how to manage those risks. The plans were focussed on supporting people to take some risks if they wanted to, rather than to remove them entirely and restrict their independence. Staff knew about risks for people and were able to tell us how they managed their needs and tried to keep them safe. For example, we observed staff supporting people to move around the home. When we checked people's care records, staff had been closely following plans which were in place to manage any identified risks around their mobility.

One person could sometimes display behaviours that could cause them or other people anxiety or distress. There were some details in their care records about the behaviours that could be displayed, but not how staff should manage them. The permanent staff we spoke with were consistent about how they managed the behaviours so that the person and others were kept safe. However, new staff who were not familiar with the person's needs may not have the knowledge to manage situations before they escalated.

One person had bed rails in use. We did not see a risk assessment for these and when asked staff could not locate one. We were told and records confirmed that the person had fallen out of bed on some occasions and that was why they were in use. We did not see any evidence that the safety of the bedrails was checked on a regular basis. Records showed and staff confirmed the person had sustained some bruising due to a gap at the side of the bed rails. Action had been taken to reduce the risk of this happening again.

We saw that some risk assessments and care plans had contradictory information on them. For example, one person had two plans in place for pressure sores which detailed different grades for the pressure sores. Other notes indicated the sores had healed. We saw a risk assessment that detailed the person should be weighed weekly but the care plan stated monthly. This did not put the person at risk as their weight was stable, however robust audits would have identified the discrepancy.

Other risks, such as those linked to the premises, or activities that took place at the service, were also assessed and actions agreed to minimise the risks. This helped to ensure people were safe in their environment. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. Records showed that when staff had reported potential risks, these had been dealt with appropriately. Maintenance work on the home was carried out when issues were reported. Staff knew what arrangements were in place in the event of a fire and were able to tell us about the emergency procedures they would follow.

People told us there were enough staff to meet their needs and keep them safe. One person said, "Staff do respond to the buzzer, you know you have to wait sometimes but not unreasonable." Relatives agreed. One told us, "They [staff] keep [name] well occupied. [Name] is always being attended to." We saw there were staff available for people at all times throughout the day. No concerns were raised with us about the staffing levels in the home. One visitor told us, "There are always at least two staff on duty." The registered manager told us 2 staff would be the minimum for each part of the home. Overall, there would be a minimum of 12 staff to cover the whole home. The registered manager told us they occasionally used agency staff, but used the same agency so people were familiar with the agency workers who came to the home to support them. The registered manager told us they had introduced a 'floating' post, which was a staff member who was not attached to any of the particular units of the home and could be called on in the event of staff sickness. They hoped this would reduce the risk of there being insufficient staff to meet people's needs.

Medicines were stored and administered safely and as prescribed, and people were supported with their medicines by staff that were trained and assessed as competent to do so. One of the assistant managers had recently taken a lead role in overseeing the safe administration of medicines at the home. They told us not all staff were able to administer medicines. We saw a senior member of staff giving people their medicines. This was done safely from a medicine trolley administering to one person at a time and ensuring the medicines had been taken. Where appropriate people were asked if they wanted their pain relief.

Where people took medicines on an 'as required' (PRN) basis, there were not always guidelines in place for staff to follow. For example, care records did not include information for staff on signs and indicators that the person might need the PRN medicines, so they received these consistently. We spoke to the registered manager about this who told us that as these medicines were locked away staff would need to speak to a

manager to get access to them. They told us the manager would explore whether or not the person's behaviour or symptoms meant they needed PRN. We looked at MAR (Medication Administration) sheets for people who were prescribed PRN medicines. These showed people were rarely given this medicine, which indicated that staff were supporting people in other ways and people were not at risk of taking too much medication.

Prescribed food supplements had not always been entered onto MAR sheets. This meant there was a risk people might be given these medicines when they did not need them, or that they would not be given them when they did. Medicines audits we looked at had not identified this as an issue recently, although the registered manager told us this had been identified before and staff had been reminded at staff meetings to enter all prescribed medicines administered on the MAR sheets.

Some people were taking 'covert' medicines, which is medicine disguised, for example in food. Records showed that discussions had taken place with medical and other professionals to determine that the person did not have capacity to make a decision around medicines, and ensured this was done in their 'best interests'.

Records showed checks had been done by assistant managers who were responsible for overseeing each of the 'wings' which made up the home. These had not always picked up on some of the issues we identified during our inspection visit. The pharmacy which supplied the home's medicines completed audits every six months. Records showed the results of these audits were shared with staff who were then aware of what they needed to do and had action taken as a result. For example, the most recent audit recommended staff should reset the medication fridge thermometer daily, to ensure accurate readings.

Good

Is the service effective?

Our findings

Relatives told us they thought staff were well trained and knew how to support people effectively. One relative told us, "The staff here are really good. They have obviously had good training."

Staff told us they completed an induction when they first started working at the service. This included face to face and online training, working alongside experienced staff and being observed in practice before they worked independently. One staff member told us, "I was given a checklist of things I had to understand over the period of my induction. I asked lots of questions to help me understand things. None of the staff made me feel like I was being a problem." The registered manager confirmed all new staff had an induction when they started working in the home. This involved attending training the provider considered essential. They also told us all new starters either came with a diploma in health and social care, or were enrolled onto a diploma once they started. The registered manager told us the diplomas were mapped against the Care Certificate which provided them with assurance that new starters had the knowledge, skills and values required to provide compassionate and high quality care and support. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

Staff told us they were well trained and knew how to support people effectively. They were satisfied with the range of training available to them. They told us they had training specifically related to the people living in the home, for example, dementia care training. We observed staff interacting and communicating with people who lived with dementia and saw they were putting their training into their everyday practice. They were communicating with people clearly and sensitively and giving people time to respond. One visiting health professional told us, "Staff seem well-trained to support people living with dementia. They know what they are doing." The registered manager told us they arranged dementia awareness training every year. They told us this was primarily for staff, but it was also opened out to relatives supporting people with dementia in the local area, as well as relatives of people living in the home who have dementia. At a recent relatives meeting, feedback on this training was positive, and relatives were asking for it to be run again.

A training record was held by the registered manager of the home, which outlined training each member of staff had undertaken and when. The provider had guidance in place which outlined what training staff should complete depending on their role. The registered manager told us they ensured this guidance was followed, and also monitored what other training staff needed. They told us this was in response to the changing needs of people being supported, as well as discussions with staff and day to day observations of their practice by the assistant managers.
The registered manager told us they were currently looking to offer specialist training in how to support people at the end of their lives in recognition of the fact that staff were doing this more often and wanted to offer the best possible care.

The registered manager told us senior staff were being trained to become trainers themselves, particularly on moving and handling. They told us this meant they could train staff more effectively and could respond to training needs identified through supervision, appraisals and staff meetings.

Staff told us they received support from senior staff when needed and they could approach the managers with any problems. They told us that staff meetings took place to keep them up to date with what was happening on the units and to raise any issues they may have. Staff told us they had regular supervision meetings with managers, which gave them the opportunity to talk about any concerns that may have and to talk about the people they were supporting. Staff told us team work on the units was good they had no concerns and if they did they would have no hesitation in approaching any of the management team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff asked for people's consent before supporting them. We observed how staff approached people and explained what they were about to do. There was clear communication, and people were asked their opinions about how they were being supported.

Some people were considered to lack capacity to make day to day decisions such as what to eat, what to drink, what to wear. This had been assessed so staff knew how much support people needed with decision making. We saw people had care plans in place that generally detailed what they could do for themselves and where they needed assistance with decision-making. Staff understood and applied the principles of the MCA. One staff member told us, "It is about people being able to make choices and decisions. Often day to day decisions like whether they want to get out of bed or not." Staff told us they offered people who were able to make day to day decisions choices about what they want to eat and what they would like to wear, for example. We saw staff offering people choices of how they spent their time, what they wanted to drink and where they wanted to sit.

The registered manager had an understanding of the legislation in place in relation to the Deprivation of Liberty safeguards (DoLS). Records showed that where restrictions were in place, these were intended to ensure the safety of people and others. Where people did not have the capacity to agree to these restrictions, they had been agreed by professionals and representatives of the person in their 'best interests'. The manager had made DoLS applications to the relevant authorities so they could be legally authorised. This protected people who could not make all of their own decisions by ensuring restrictions were proportionate and were not in place without the relevant authorisation. This ensured the provider and manager were acting to protect people's rights under the Mental Capacity Act.

Risks to people's nutrition and hydration were minimised. We saw that people with specific needs and risks in relation to their diet had had a nutritional assessment and care plans were in place detailing actions required. Where people were at high risk associated with their diet or fluids they were referred to the appropriate medical professionals, for example, dieticians and speech and language therapy teams. Staff were able to tell us about people's specific needs in relation to their diets, for example, who required thickened fluids and soft diets. Records showed people's weights were monitored. There was a table on each of the units with snacks including fruit and packets of crisps for people to eat if they wanted to. We spoke with visitors to the home who told us they had been concerned about their friend's weight gain. They had discussed this with staff who had referred the person to the dietician for advice. We were told the person had now lost weight and appeared much more comfortable. People who needed specific diets had their needs met. A member of the kitchen staff told us, "SALT (Speech and Language Therapy) come in and

assess what sort of food people can eat. I get written confirmation from them so I can meet people's needs if they need pureed food for example. We saw food was well presented and looked appetising. A member of the kitchen staff told us, "A picture on a plate, that's what I try and provide. People with dementia for example often eat with their eyes."

People we spoke with were generally satisfied with the meals at the home. One person told us, "(The food) is pretty good we get a choice." Another person said, "Food is very good, I eat in the dining room, we get choices."

People were supported to access support and advice from health professionals on a routine basis as well as when sudden or unexpected changes in their health occurred. Relatives were confident people got medical attention when they needed it. One told us, "[Name] was having falls so the staff got the hospital involved. It's sorted now." External health professionals were confident staff supported people with specific health conditions effectively. One told us, "They are really good at managing people's health conditions. If they need to get someone they contact us straight away." Records showed that people had access to a range of health care professionals to ensure their ongoing health care needs were being met. During the course of the inspection we saw nurses and chiropodist visiting people and were told the doctor was visiting that day also. One person told us they had a pacemaker and this was checked regularly. A visitor told us, "The nurse visit (person's name) to check on them."

Good

Is the service caring?

Our findings

People told us staff were kind and caring and treated them with respect. One person told us, "Very nice the staff are." People told us staff tried to create a positive, homely atmosphere. One person told us, "It is just like being at home here really." We saw people interacting on a one to one basis with staff. People seemed relaxed and responded well to staff input. Staff were also attentive to people's needs and were quick to react when someone appeared to be in discomfort. Over lunch for example, one person was coughing repeatedly. Staff gently reassured the person and offered them more gravy for their food in case it was too dry. They also ensured the person had sips of their drink which seemed to reassure them. Staff talked gently to people, laughed with them, and involved them in activities such as completing puzzles and looking through newspapers and magazines with them. Relatives felt there was a caring, family-type atmosphere which helped people to feel cared for and valued. One relative told us, "We are very impressed with the care. Staff are so approachable. (Person) gets very anxious we've seen the staff sit and hold her hand." Another told us, "Staff have a good repertoire with people. They are very gentle."

People's care plans were written from the person's point of view. Relatives told us they had been involved in reviewing people's care plans where people were unable to do this themselves. One relative told us, "We go through the care plan with the staff here every year." Staff had taken time to find out about people's likes, dislikes and preferences, as well as their history. This meant staff could speak with people about things that mattered to them. It was evident from the staff we spoke with that they knew the people who lived at the home well and had learned their likes and dislikes. We saw that people were asked to make a variety of decisions about their care during the day, for example, what they wanted to eat and drink, if they wanted to take part in an activity and where they wanted to sit.

The registered manager had tried to ensure people's environment was comfortable and personal to them. For example, people had been asked what view they would like to see through their window, and an artist had been brought in to paint a picture depicting that scene on the wall next to the person's room door.

Care plans helped staff support people to become as independent as possible. They included information on what people could do for themselves and what people needed assistance with. Staff told us they encouraged people to be as independent as possible. They were able to tell us what people were able to do for themselves and what they needed assistance with. One staff member told us, "If we are helping someone get dressed for example, we ask people if they want to do things themselves. Like giving someone their own toothbrush rather than brushing their teeth for them."

People were supported to maintain relationships with family and friends. One person told us, "My family visit all the time, they take me out." Relatives told us they could visit people whenever they were invited to do so. One relative told us, "We can visit whenever we want. We are always made to feel welcome." We saw that many of the people living at the home had their own telephones in their bedrooms so they were able to keep in touch with their relatives. The registered manager told us relatives were free to visit whenever they wanted to, provided people were happy with this. They advised they asked people to avoid mealtimes if possible, but that many relatives travelled long distances to see people so this was flexible. They added that

at Christmas time, relatives who had travelled a long way were able to stay at the home if there was a spare room to enable people to spend Christmas with relatives if they wanted to.

People told us their privacy and dignity was respected. They told us they had keys for their bedrooms if they wanted to lock them. One person told us, "Staff knock the door, I leave it unlocked." We observed that people were asked discreetly about their personal care. We also saw that where people were being supported by health professionals, this was done in a private, closed off part of the home so people had their privacy and dignity maintained.

We saw people's personal details and records were held securely at the home. Records were filed in locked cabinets and locked storage facilities, so that only authorised staff were able to access personal and sensitive information.

Good

Is the service responsive?

Our findings

People indicated they were able to make choices about what they wanted. One person told us, "They do what you ask them to do." Staff told us people were able to choose what they wanted to eat for example. A member of the kitchen staff told us, "I have residents feedback forms on the food here and I put the menus together based on that." They told us people did not have to eat any of the options on the menu. They added, "If someone does not want to eat something [on the menu] there are always alternatives. We will meet any request." We saw there was information on display for people on which staff were on duty, what the choices were for lunch, and what activities were on offer that day. Where people could not read or fully understand written information, staff explained this to them so they could make decisions about what they wanted.

People told us about their care plans and explained that staff knew how to meet their needs. One person told us, "I have a care plan and I met the lead care worker just after I came in." We saw that people had an overview of their needs in their bedrooms which detailed how they preferred staff to deliver the care and support they required. One visitor showed us this document in their friends' room and said, "This care plan is very important it tells people about (name of the person)." Staff told us they acted as 'keyworkers' for people, and that one of their responsibilities was to ensure people's care plans were up to date so that people's changing needs were met according to their wishes. One staff member told us, "We often either come in an hour early or stay an hour late to update people's records, which we are responsible for." People's care plans included information which gave some of their past history. This gave staff information they could talk to people about and helped them understand people. Staff we spoke with were aware of people's needs and were able to tell us what they liked, how they wanted to be cared for and what they were able to do for themselves.

Relatives told us staff supported people according to their needs and responded effectively as their needs and abilities changed. They also told us they were involved in helping staff get to know people better. One relative told us, "They ask us for things for reminiscence in [name's] room so they can talk to [name] about them and communicate with them."

People were supported to maintain activities that they enjoyed, and were given opportunities to try new things. The range of activities varied throughout the home. We saw in one part of the home that people were having their hair done, their nails manicured, baking some cakes and playing a musical instrument. On another wing people were playing dominoes. Some of the people living in the home facilitated their own hobbies. For example, we saw people knitting, doing puzzles and reading the daily newspapers. People had mixed views about the range of activities available to them. One person told us, "Sometimes people come in but this is usually downstairs. I do get bored." Another person said there were activities but they did not want to take part didn't get bored. A third person told us, "I have the [named newspaper] every day to read, I look through the window, I try to go to mass every morning." The registered manager told us there was no staff member specifically assigned to oversee activities at the home, and that all staff were responsible for engaging people in activities they chose and enjoyed.

People told us they were supported to meet their religious and cultural needs. Mass was held in the chapel at the home every day, as the home specifically catered for people of the Catholic faith. People appeared to look forward to this. One of the visitors told us, "[Name] goes to the service every day, Father adapts it to their understanding." There was also a monthly Church of England service, as well as a monthly 'songs of praise' celebration. The registered manager told us if people followed other faiths, they would bring people in from the local community who could help people met their religious and spiritual needs.

People told us if they had any concerns they would tell the manager about them. They felt confident they would be listened to. One person told us, "I would go to the manager with any concerns." Another person said, "I have no concerns or problems being here." The registered manager had not received any complaints in the past 12 months. There was information on display about what people could expect and how to complain if they were not happy with anything. There was information available for people in an 'easy read' format to help people to understand their rights. 'Easy read' formats use visual images and large print sizes to make the documents more accessible to people. There were policies and procedures for staff to follow to ensure complaints were dealt with effectively.

Good

Is the service well-led?

Our findings

Relatives and staff told us the registered manager was effective in their role, approachable and responsive if they had any issues. One relative told us, "[Registered manager] is very good. We chatted things through and got things sorted." The manager had been employed at the home for a considerable amount of time and appeared knowledgeable about the needs of the people living there Staff were positive in their comments about the registered manager saying they were listened to. Staff were also positive about the support they received from the assistant managers. One staff member told us, "They are really good. You can always talk to them." Another staff member told us, "They are a very supportive management team. They all have their own skills." Staff also told us any extra work they did in order to ensure people were well supported was recognised by the provider which made them feel valued. "We get paid for any extra time we spend doing extra work, updating care plans for example."

Staff told us they followed the registered manager's example in creating an open, honest culture. We observed there was a homely atmosphere where people were relaxed and calm. There were open and honest discussions between people, staff and managers which staff told us helped people and the staff supporting them to feel valued and respected. The registered manager told us they encouraged staff to put people first. They told us, "I want people to be safe, happy and have their rights protected. I encourage staff to work in this way." The registered manager also told us they ensured they worked different times throughout the week so they saw night staff, for example. They told us they thought it was important that they were visible and were seen to be working the same as everyone else. They told us, "You shouldn't ask people to do things you don't want to do."

The registered manager was supported by one deputy manager and four assistant managers. The registered manager told us the provider was responsive to requests for support, which meant they were better able to manage the service effectively for people. The registered manager told us each of the assistant managers was responsible for managing one of the units, which they said had helped them focus on managing the home as a whole. They told us the assistant managers had been given one day per week to focus on their unit, which they used for supervisions, updating care plans, conducting observations.

Staff told us they had the opportunity to share their views at staff meetings. Records showed staff had the opportunity to discuss the developing needs of people living in the home and share any concerns they might have. Staff told us they were listened to and that made them more likely to share their views. They told us issues were discussed, actions were agreed and progress on actions was fed back by the registered manager.

The provider had established effective links with the local community. For example, the registered manager worked with local colleges. Students who were studying health and social care came to work in the home as part of their study. The registered manager ensured students worked alongside staff on a particular unit so that people received care and support from a consistent staff team.

The provider had systems in place to gather the views of people, relatives and others with a view to learning

more about the service they provided and how it could be improved. Satisfaction surveys were issued every three months to establish what people and their families thought about the service being provided. The completed surveys went to the provider for analysis. We looked at the outcome of the most recent surveys. The provider had written a brief report for the registered manager highlighting the positive elements and what could be further improved. The outcome of the surveys and the report were sent out to relatives. However there was no action plan with the report to say when any improvements would be made. We discussed this with the registered manager and the provider who agreed they would begin adding this information to the report.

Meetings for the people living in the home had lapsed. The manager stated these were just starting again and staff were trying to encourage people to attend. We were told people's views and opinions were obtained by talking to them. For example, the registered manager told us some of the people living in the home had told staff they found the call bell alarms very loud and unsettling. The registered manager advised us the system was therefore due to be replaced with one where the alarms had a softer tone. There were daily dietary comment sheets and any comments made were passed back to the chef. We were told that people were consulted about the décor in their bedrooms to establish what colours they wanted for paint and carpets.

There were systems in place to monitor the quality and safety of the service with a view to improving it. However, some of the discrepancies we found had not been identified by the auditing systems, for example, the lack of recording around bruising and staff not following the correct procedures. We spoke with the registered manager about this, who agreed audits had not always been effective in identifying the issues we had raised. The registered manager agreed they needed to ensure audits were more robust and reliable, and advised they would be looking quickly at how they could achieve this.

The registered manager understood their legal responsibility for submitting statutory notifications to us. This included incidents that affected the service or people who used the service. These had been reported to us as required throughout the previous 12 months.